

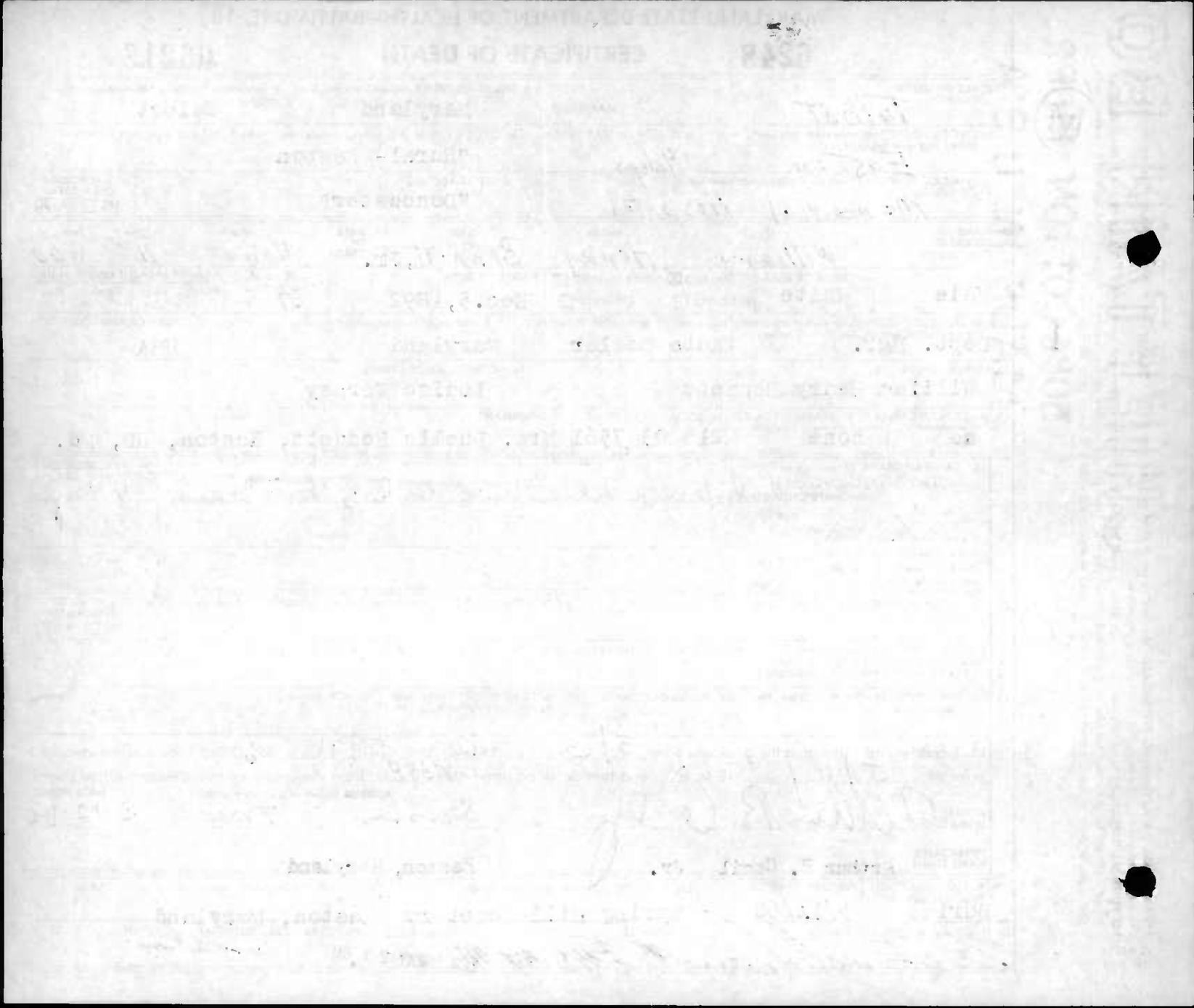
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6248

CERTIFICATE OF DEATH

06212
Reg. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>9 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>William</i>	Middle <i>Henry</i>	Last <i>Bennett, Jr.</i>
4. DATE OF DEATH <i>May 11 1960</i>	Month Day Year		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 5, 1892</i>
9. AGE (In years last birthday) <i>67 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dept. Mgr.</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Auto Dealer</i>	12. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>William Henry Bennett</i>	14. MOTHER'S MAIDEN NAME <i>Louise Vernay</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>216 03 7561</i>		INFORMANT <i>Mrs. Luella Bennett, Easton, RD, Md.</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Inferior mesenteric artery thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>570.2</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5/1/3</i> , 19 <i>60</i> to <i>5/11</i> , 19 <i>60</i> that I last saw the deceased alive on <i>5/11/60</i> , and that death occurred at <i>4:38 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Arthur B. Cecil Jr.</i>		ADDRESS (Street, city or town, state) <i>Sussex St. Easton, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>Arthur B. Cecil Jr.</i>		DATE SIGNED <i>5-12-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5/14/60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Spring Hill Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Easton, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Thompson Carroll, EASTON, MD.</i>		24a. REC'D BY REGISTRAR <i>MAY 23 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Cecil B. Finch</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06213

6249

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>8 hrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>40 Easton</i>		d. STREET ADDRESS <i>S. Washington St.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Easton Memorial Hosp</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>John William Bowling</i>		First <i>John</i>	Middle <i>William</i>	Lost <i>Bowling</i>	4. DATE OF DEATH <i>May 9 1960</i>	Month <i>May</i>	Day <i>9</i>	Year <i>1960</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 27, 1876</i>		9. AGE (In years lost birthday) <i>83 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Printer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>retired</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Richard Bowling</i>		14. MOTHER'S MAIDEN NAME <i>Emma Jennings</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>214 05 1154</i>		INFORMANT <i>Mrs. J.W. Bowling, Easton, Maryland</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>490X</i>		DUE TO <i>Arteriosclerosis generalized</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerosis generalized</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>alive on 5/9/60, and that death occurred at 8:30 p.m.</i>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Easton, Maryland</i>	(County) <i>Wicomico Co.</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ p.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Easton, Maryland</i>								
ACTUAL SIGNATURE <i>P. E. Cox</i>		DATE SIGNED <i>4/9/60</i>						
PHYSICIAN'S NAME (Type) <i>P. E. Cox, M.D.</i>		Easton, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/12/60</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Hillcrest Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Federalsburg, Maryland</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Hampton (and) Easton, MD</i>		ADDRESS <i>W. Hampton (and) Easton, MD</i>		24a. REC'D BY REGISTRAR <i>MAY 23 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA
CERTIFICATE OF DEATH

833

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6273 MEDICAL EXAMINER'S CERTIFICATE OF DEATH06214
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bellevue		c. LENGTH OF STAY IN 1b 21 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bellevue		d. STREET ADDRESS /		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)								
3. NAME OF DECEASED (Type or print) BESSIE L. CAMPBELL		First	Middle	Last	4. DATE OF DEATH MAY 9 1960	Month	Day	Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 27, 1894	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME ? Ramsey				14. MOTHER'S MAIDEN NAME Mary Valentine				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Samuel King Address Alexandria, Va.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE- RECURRENT INTERVAL BETWEEN ONSET AND DEATH 443 X 1ST-OCT. '59 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) HCVD & GENERALIZED ARTERIOSCLEROSIS DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Louis S. Welty</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 5-10-60			
EXAMINER'S NAME (Type) LOUIS S. WELTY	22d. LOCATION (City, town, or county) (State) Oxford, Maryland							
22b. BURIAL, CREMATION, REMOVAL (Specify) Burial	22c. DATE THEREOF May 11, 1960	22d. NAME OF CEMETERY OR CREMATORIAL ADDRESS Oxford Cemetery Easton, Md.		24a. REC'D BY REGISTRAR May 11 '60				
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		24b. REGISTRAR'S SIGNATURE Charles S. Kraus						

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06215

6250

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		a. PLACE OF DEATH a. COUNTY <u>TALBOT</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN 1b <u>10 days.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON Memorial Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Easton</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr James</u>		First <u>J.</u>	Middle <u>I.</u>	Last <u>Campbell</u>	4. DATE OF DEATH Month <u>May</u> Day <u>3</u> , Year <u>1960</u>
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Oct. 12 1904</u>	9. AGE (In years last birthday) <u>55</u> yrs. <u>5</u> months <u>27</u> days <u>0</u> hours <u>0</u> min. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>James John Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Kate Beel Baurewich</u>		12. CITIZEN OF WHAT COUNTRY? <u>Address</u> <u>5125 Babcock Place Pittsburgh Pa</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Matthew G. Corrigan</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Heart failure</u> <u>Coronary occlusion</u>			
420-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO		(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <u>2:40 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>2195 Washington St 41660</u> DATE SIGNED <u>16 May 1960</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 5-1960</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Celtic Cemetery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Schmidt</u>		ADDRESS <u>Easton Md</u>		24a. REC'D BY REGISTRAR DATE <u>Arthur S. Hanna</u> MAY 5 '60	
				24b. REGISTRAR'S SIGNATURE	

STATE OF OREGON
CERTIFICATE OF DEED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6251

CERTIFICATE OF DEATH

Reg. Dist. No.

06217

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYland</i>		b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>Life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>40 Easton</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>407 south st</i>				d. STREET ADDRESS <i>/</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>EMMA</i>	Middle <i></i>	Last <i>Copper</i>	4. DATE OF DEATH <i>5 5 1960</i>	Month <i>5</i>	Day <i>5</i>	Year <i>1960</i>
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5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/1/85</i>	9. AGE (In years last birthday) yrs. <i>64</i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>	Hours <i></i>	Min. <i></i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic Maryland</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>Jake Rakes</i>	14. MOTHER'S MAIDEN NAME <i>Fanny Murray</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>Phillip Copper, Easton, Md.</i>	Address <i></i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>153.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i></i>		<i>Carcinoma (cervix) (metastatic adenocarcinoma) August '57</i>
DUE TO (b) DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
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20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day <i></i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
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21. I certify that I attended the deceased from <i>4/6</i> , 19 <i>59</i> , to <i>5/5</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>4/11</i> , 19 <i>60</i> , and that death occurred at <i>10 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>L. J. Egleden M.D.</i>	ADDRESS (Street, city or town, state) <i>12 N. 11th St. Easton</i>		DATE SIGNED <i>5/6/60</i>				

PHYSICIAN'S NAME (Type) <i>L. J. Egleden</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/8/60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Williamsburg Cem</i>	22d. LOCATION (City, town, or county) <i>Easton</i>	(State) <i>Md.</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Donnell Easton, Md.</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR DATE <i>MAY 16 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be joined by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MICHIGAN STATE DEPARTMENT OF HEALTH - DIVISION OF

CERTIFICATE OF DEATH

MICHIGAN

DECEASED'S NAME	AGE	SEX	CAUSE OF DEATH
WILLIAM H. GIBSON	65	M	HEART DISEASE
ADDRESS	AGE AT DEATH	TIME OF DEATH	TIME OF DEATH
1111 W. GRANGE AVE.	65	10:00 P.M.	10:00 P.M.
CITY	STATE	ZIP CODE	PHONE NUMBER
DETROIT	MI	48203	555-1234
NAME AND ADDRESS OF DOCTOR	NAME AND ADDRESS OF FUNERAL HOME		
DR. JAMES M. SMITH	DETROIT FUNERAL HOME		
RELATIONSHIP TO DECEASED	RELATIONSHIP TO DECEASED		
SPOUSE	SPOUSE		
WILLIAM H. GIBSON	WILLIAM H. GIBSON		
WITNESSES	WITNESSES		
DR. JAMES M. SMITH	DETROIT FUNERAL HOME		
DETROIT, MICHIGAN	DETROIT, MICHIGAN		
DATE	TIME		
10/10/91	10:00 P.M.		
APPROVED	APPROVED		
DR. JAMES M. SMITH	DETROIT FUNERAL HOME		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06218

1. PLACE OF DEATH a. COUNTY <i>Saint</i>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Beverly St. Michaels</i>	c. LENGTH OF STAY IN 1b <i>1</i>	b. COUNTY <i>Saint</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Beverly Eastern</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rio Vista Nursing Home</i>		d. STREET ADDRESS <i>1</i>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>Mary</i>	Middle <i>Louise</i>	Last <i>Dudley</i>		
4. DATE OF DEATH	Month <i>May</i>	Day <i>8</i>	Year <i>1960</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 29, 1890</i>		
9. AGE (In years last birthday) <i>69</i>	10. IF UNDER 1 YEAR Months <i>6</i>	11. IF UNDER 24 HRS. Days <i>9</i>	12. Hours <i>0</i>		
13. FATHER'S NAME <i>Thomas Ansgarile Dudley</i>	14. MOTHER'S MAIDEN NAME <i>Mary Louise Dudley Ruthell</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or Unknown) <i>No</i>			
16. SOCIAL SECURITY NO. <i>Reuben Pounds, R. E. Clark,</i>	17. INFORMANT <i>Easter Md</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO <i>atherosclerotic occlusive cardio vascular disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>-</i>		(b) DUE TO <i>-</i>	(c) <i>-</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>embolism atherosclerotic occlusive vascular</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>from the causes and on the date stated above.</i>				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>4-21 - 1960</i>	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/> <i>19</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>-</i>	20f. (City or town) <i>-</i>	(County) <i>-</i>	(State) <i>-</i>
21. I certify that I attended the deceased from <i>4-21 - 1960</i> to <i>5-8 1960</i> that I last saw the deceased alive on <i>4-21 - 1960</i> , and that death occurred at <i>10:55 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>St. Michaels Md</i>					
ACTUAL SIGNATURE <i>Mary M. Beeson</i>	PHYSICIAN'S NAME (Type) <i>Mary M. Beeson</i>	M.D.	DATE SIGNED <i>5-9-60</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>May 11, 1960</i>	22b. DATE THEREOF <i>May 11, 1960</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Spring Hill</i>	22d. LOCATION (City, town, or county) <i>Eastern</i>	(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Reuben Clark</i>	ADDRESS <i>Eastern Md</i>	24a. REC'D BY REGISTRAR DATE <i>MAY 11 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6252

See: Birth Cert. et

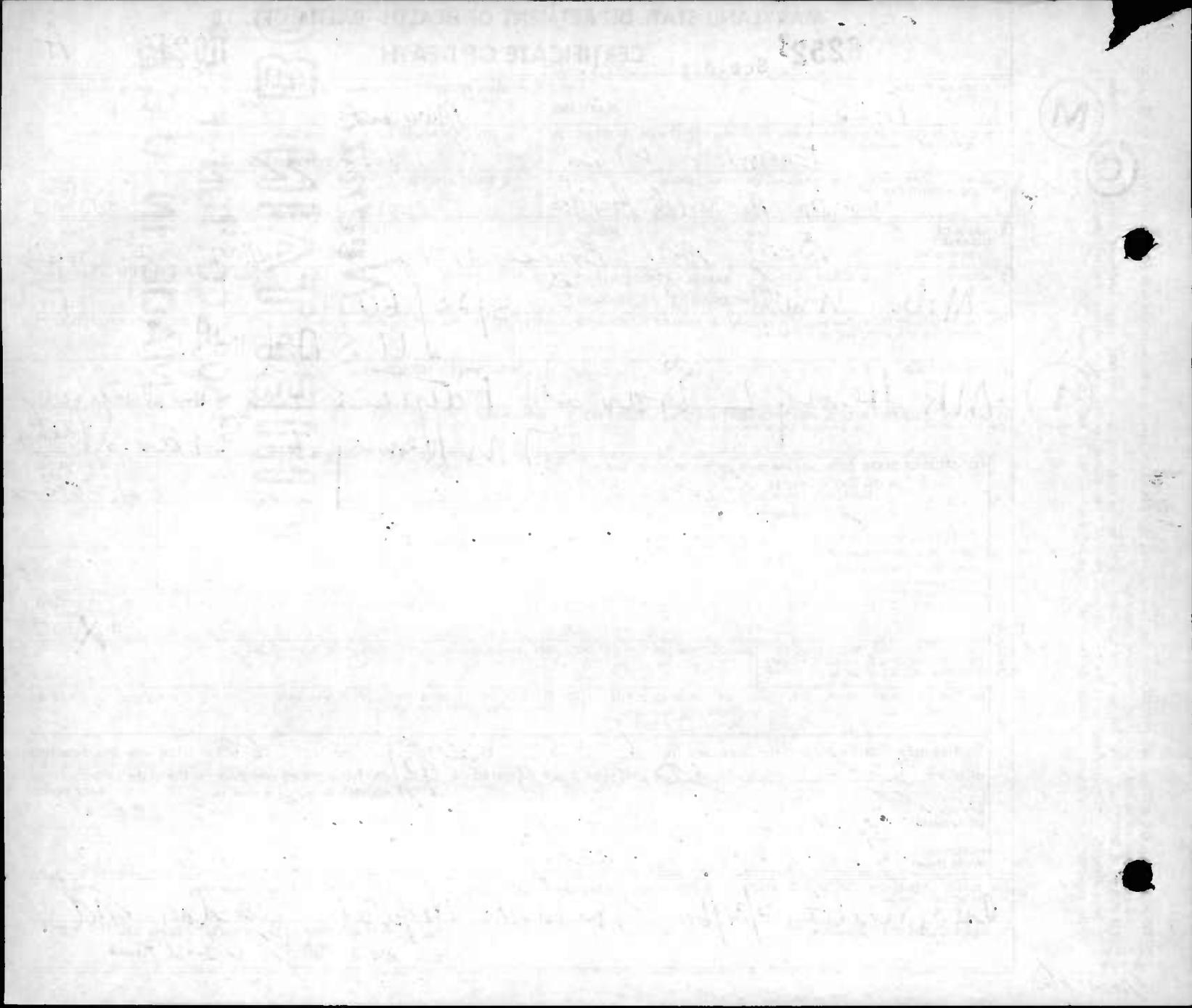
06219
Reg. Dist. No.

A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 47 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy Evans (A)		First Baby	Middle Boy
4. DATE OF DEATH Month May Day 25 Year 1960		5. SEX Male	6. COLOR OR RACE White
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 5/25/60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S.A. (Md.)	
11. BIRTHPLACE (State or foreign country) U.S.A. (Md.)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME MR Henry L Evans		14. MOTHER'S MAIDEN NAME Patricia Lee Rednour	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) DUE TO (d) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 47 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) EASTON (County) Maryland (State) Md.	
21. I certify that I attended the deceased from 5-25 , 19 60 to 5-25 , 19 60 , that I last saw the deceased alive on 5-25 , 19 60 , and that death occurred on 5-25 , 19 60 , from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry M. Reeser		ADDRESS (Street, city or town, state) St. Michaels Md.	
PHYSICIAN'S NAME (Type) Henry M. Reeser		DATE SIGNED 5-25-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5/31/60	
22c. NAME OF CEMETERY OR CREMATORIAL Memorial Hospital		22d. LOCATION (City, town, or county) EASTON MD (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Krause		24a. REC'D BY REGISTRAR DATE SUN 3 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06220
Reg. Dist. No.

B

6253

See: Birth Cert. et

1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 1 hr - 52 min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easter Memorial Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X St. Michaels	
3. NAME OF DECEASED (Type or print) Baby		d. STREET ADDRESS Maple Street	
First Baby		Middle Boy	Last Evans (B)
5. SEX Male		4. DATE OF DEATH Month May Day 25 Year 1960	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 5/25/60		9. AGE (In years lost birthday) yrs. 11 IF UNDER 1 YEAR Months Days Hours Min 11 0 0 0 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Md	
13. FATHER'S NAME Mr Henry L Evans		14. MOTHER'S MAIDEN NAME Patricia Lee Lednay	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Mr Henry L Evans	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 776X (b) Drunkeness DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 1 hr 52 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-25-60 to 5-25-60 , 1960, that I last saw the deceased alive on 5-25-60 , and that death occurred at 11:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry L. Evans Jr.		ADDRESS (Street, city or town, state) St. Michaels Md	
PHYSICIAN'S NAME (Type) Henry L. Reeker Jr.		DATE SIGNED 5-25-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 5/25/60		22b. DATE THEREOF 5/25/60	
22c. NAME OF CEMETERY OR CREMATORIAL LOCATION (City, Town, or county) Memorial Hospital, Easton Md		22d. LOCATION (City, Town, or county) (Specify)	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Evans		24a. REC'D BY REGISTRAR DATE JUN 3 '60	
ADDRESS 2380264xv1		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8 DECEMBER 1944
RECORDED BY STATE CHAMBER
MAILED TO TACOMA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

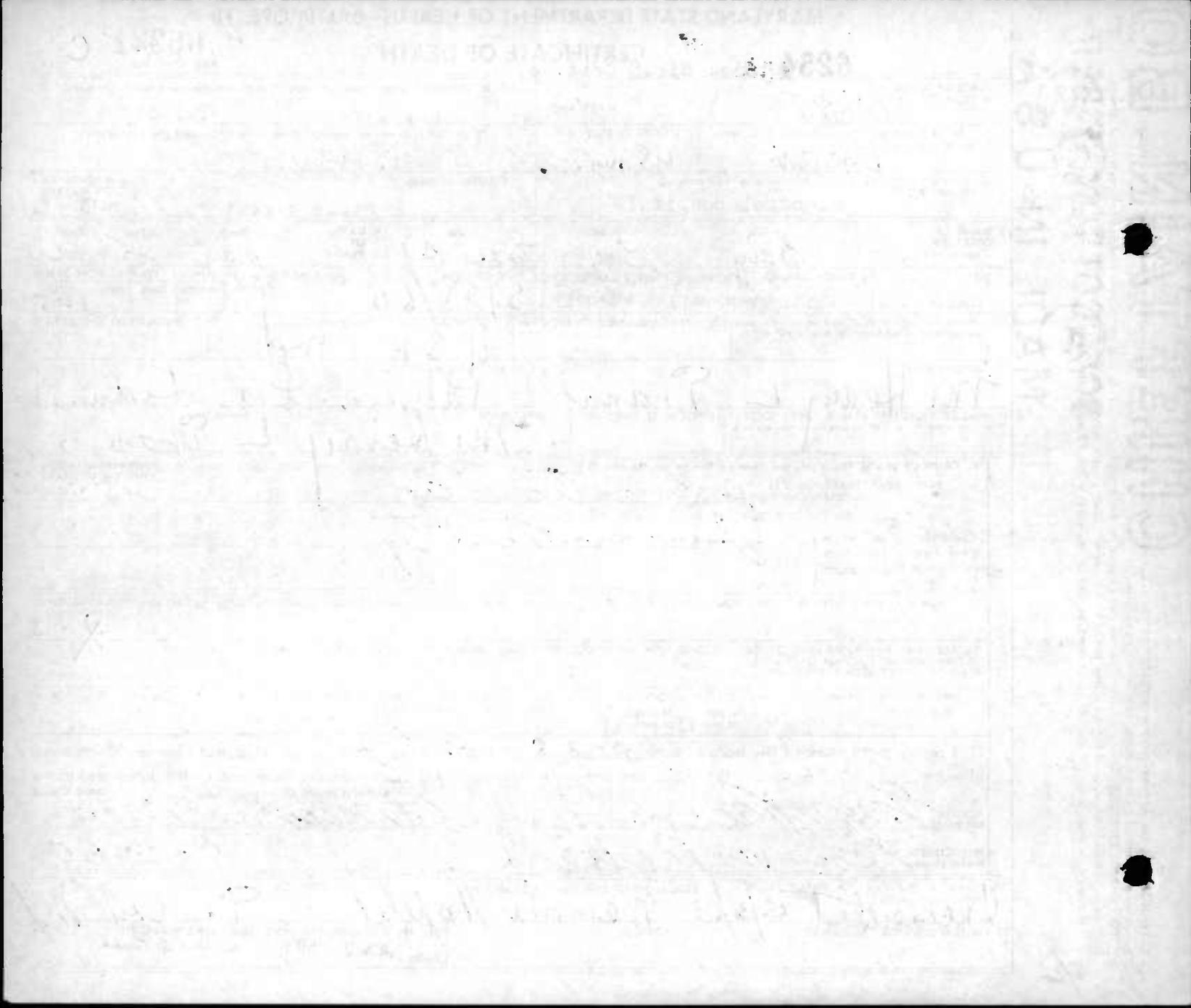
CERTIFICATE OF DEATH

66221 C
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>TALBOT</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>	c. LENGTH OF STAY IN 1b <i>45 min.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X St. Michaels</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>	d. STREET ADDRESS <i>1 Maple Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Baby</i>	First <i>Baby</i>	Middle <i>Boy</i>	Last <i>Evans (c)</i>		
4. DATE OF DEATH Month <i>May</i>	Day <i>25</i>	Year <i>1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/25/60</i>		
9. AGE (In years lost birthday) yrs. <i>0</i>	10. IF UNDER 1 YEAR Months <i>0</i>	Days <i>0</i>	Hours <i>45</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>U.S.A. Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>None</i>		
13. FATHER'S NAME <i>Mr Henry L Evans</i>	14. MOTHER'S MAIDEN NAME <i>Barbara Lee Lednuss</i>	Address <i>Mr Henry L Evans</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>776X</i>	INFORMANT <i>Mr Henry L Evans</i>	INTERVAL BETWEEN ONSET AND DEATH <i>45 min</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Prematurity</i> DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5-25-60</i> , to <i>5-25-60</i> , that I last saw the deceased alive on <i>5-25-60</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>John W. Reeker</i>				ADDRESS (Street, city or town, state) <i>St. Michaels Md</i>	DATE SIGNED <i>5-25-60</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremated</i>	22b. DATE THEREOF <i>5/31/60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Memorial Hospital</i>	22d. LOCATION (City, town, or county) (State) <i>Easton Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Reeker</i>	ADDRESS <i>2380265 X VO</i>	24a. REC'D BY REGISTRAR DATE <i>JUN 3 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6255

CERTIFICATE OF DEATH

06222

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

080

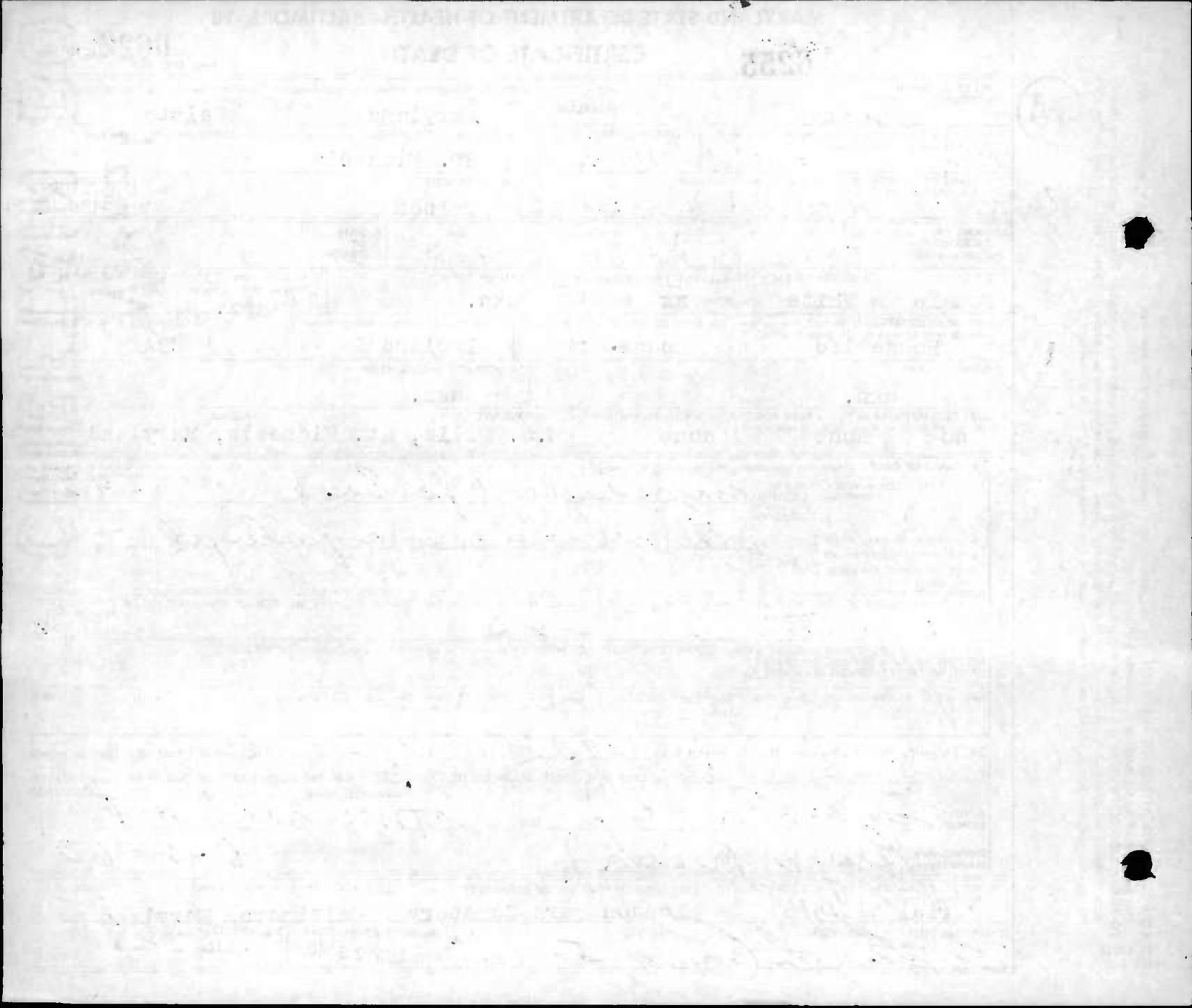
I

O

I

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE	
Talbot		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b RURAL and give nearest town)	
EASTON		17 hr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Memorial Hospital			
3. NAME OF DECEASED (Type or print)		First	Middle
ANNIE		DALTON	Foster
4. DATE OF DEATH		Month	Day
		5	2
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
Female		White	u kn.
8. DATE OF BIRTH		9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
u kn.		87 apx.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		housework	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Ireland		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
u kn.		u kn.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service) none		INFORMANT	
		W.C. Mills, St. Michaels, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>420.1</i>		2-4 hrs	
{ (b) <i>atherosclerotic coronary artery d</i> DUE TO (c)		-	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <i>Hypertensive crv d</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1952</i> , 19, to <i>5-2</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>5-2</i> , 19 <i>60</i> , and that death occurred at <i>9 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>George Reeser</i>		DATE SIGNED <i>5-2-60</i>	
PHYSICIAN'S NAME (Type) <i>George Reeser</i>		M.D. <i>St. Michaels Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/5/60	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Hampton Card, Jr. Minn</i>		24a. REC'D BY REGISTRAR DATE MAY 23 '60	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6256 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>11 hrs</i>		d. a. STATE <i>Maryland</i> b. COUNTY <i>Caroline</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Easton Memorial Hospital</i>		e. STREET ADDRESS <i>Rural Goldsboro</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>05X-2</i>	
3. NAME OF DECEASED (Type or print) <i>John George Gavoille</i>		First	Middle	4. DATE OF DEATH <i>May 8</i>	Month Year <i>1960</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-26-1947</i>	9. AGE (In years from last birthday) <i>13 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>	
13. FATHER'S NAME <i>John Millard Gavoille</i>		14. MOTHER'S MAIDEN NAME <i>Violet E. Wardleworth</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>John M. Gavoille Goldsboro, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Skull Fracture - Conscious confusion 11 hrs - 812X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Decance of Brain</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Struck by Automobile -</i>					
20c. TIME OF INJURY Hour o. m. p. m. <i>48</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <i>Rural</i>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Goldsboro Milford Caroline Md</i>	
20f. (City or town) <i>Goldsboro</i>		(County) <i>Caroline</i>		(State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>George J. Gavoille</i> EXAMINER'S NAME (Type) <i>DAVISON J. GAVOILLE</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-10-60</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Milford Memorial</i>	
22d. LOCATION (City, town, or county) <i>Milford, Penna.</i>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John E. Boulaia Greensboro Md</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 12 '60	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

DEEDICATE EXHIBIT 2 CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician and completely filled in by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6257

CERTIFICATE OF DEATH

06225

Reg. Dist. No.

1. PLACE OF DEATH
o. COUNTY

Talbot

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Easton

c. LENGTH OF STAY IN 1b

4-hours

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

o. STATE

MARY/land

b. COUNTY

Talbot

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

40E EASTON

d. STREET ADDRESS

1121 Port St

e. IS RESIDENCE ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First
John

Middle

Last
Hines

4. DATE
OF
DEATH

Month
May

Day
16
Year
1960

5. SEX

Male

6. COLOR OR RACE

Col

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

3/12/14

9. AGE (In years
lost birthday)

44 yrs.

10. UNDER 1 YEAR IF UNDER 24 HRS.

Months
Days
Hours
Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Labor

10b. KIND OF BUSINESS OR INDUSTRY

Factory

11. BIRTHPLACE (State or foreign country)

MARY/land

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Hines

14. MOTHER'S MAIDEN NAME

LIZZIE Copper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

—

16. SOCIAL SECURITY NO.

314-16-7516

INFORMANT

Address

Lizzie Hines, Eastern Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Subarachnoid hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH

4 hrs.

DEUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

(b)

DEUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.

20d. INJURY OCCURRED
While Not while
of work of work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased
alive on _____, 19_____, and that death occurred at 2:30 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Robert W. Trevor

M.D.

PYCHIAN'S
NAME (Type)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

3/19/60

22c. NAME OF CEMETERY OR CREMATORI

Richards Cem.

22d. LOCATION (City, town, or county)

Boston

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

JAMES O' BRIEN

EASTON, MD.

24a. REC'D BY REGISTRAR

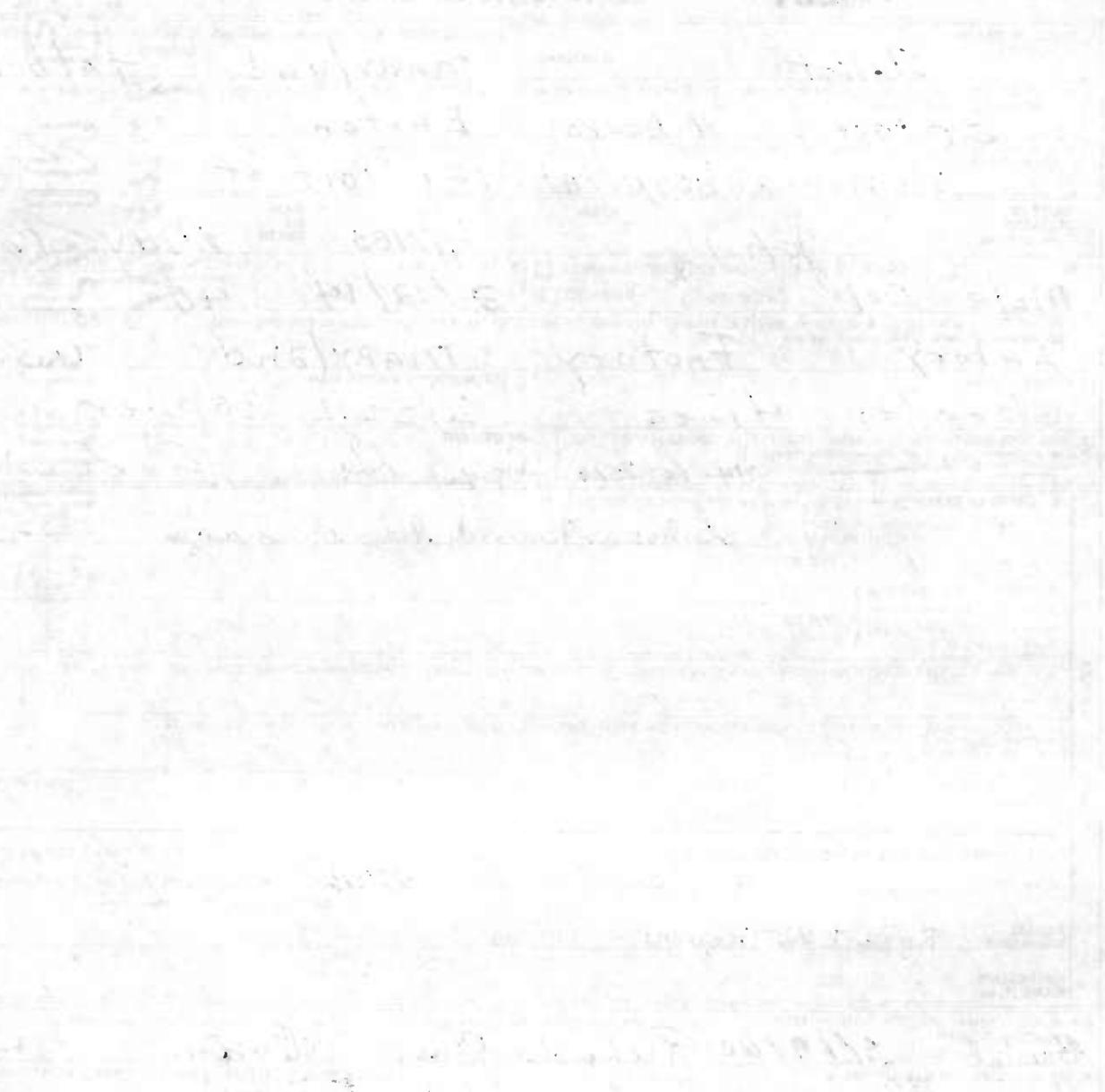
JUN 1 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Thorne

BY STATION - REASSEMBLED IN THIS ORDER

STATION NO. 10 STATION NO. 11



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6258

CERTIFICATE OF DEATH

06226

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>11 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Easton Memorial Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Mrs</i>	Middle <i>Rosalie</i>	Last <i>Hollingsworth</i>
4. DATE OF DEATH	Month <i>May</i>	Day <i>7</i>	Year <i>1960</i>
5. SEX <i>Fem.</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 2 - 1888</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Bowers PAYNE</i>	14. MOTHER'S MAIDEN NAME <i>JULIA HOLLINGSWORTH</i>	Address <i>VIRGINIA HOLLINGSWORTH CHURCH Hill</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	INFORMANT	INTERVAL BETWEEN ONSET AND DEATH <i>5 hr.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.</i> Due to <i>Chronic rheumatism</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebral vascular accident</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>falling down</i>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>26 Apr.</i> , 1960, to <i>7 May</i> , 1960, that I last saw the deceased alive on <i>7 May</i> , 1960, and that death occurred at <i>3:15 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Thurston Harrison</i>	ADDRESS (Street, city or town, state) <i>Carver, Maryland</i> DATE SIGNED <i>May 12 1960</i>		
PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>	M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>5/10/60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Centreville</i>	22d. LOCATION (City, town, or county) <i>Centreville</i> (State) <i>MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elgar L. Lane</i>	ADDRESS <i>Church Hill</i>	24a. REC'D BY REGISTRAR <i>MAY 12 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Evans</i>

CLASSIFIED BY

CLASSIFICATION AUTHORITY

DATE OF CLASSIFICATION

1950 NOV 19 1982

BY CSB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6259

CERTIFICATE OF DEATH

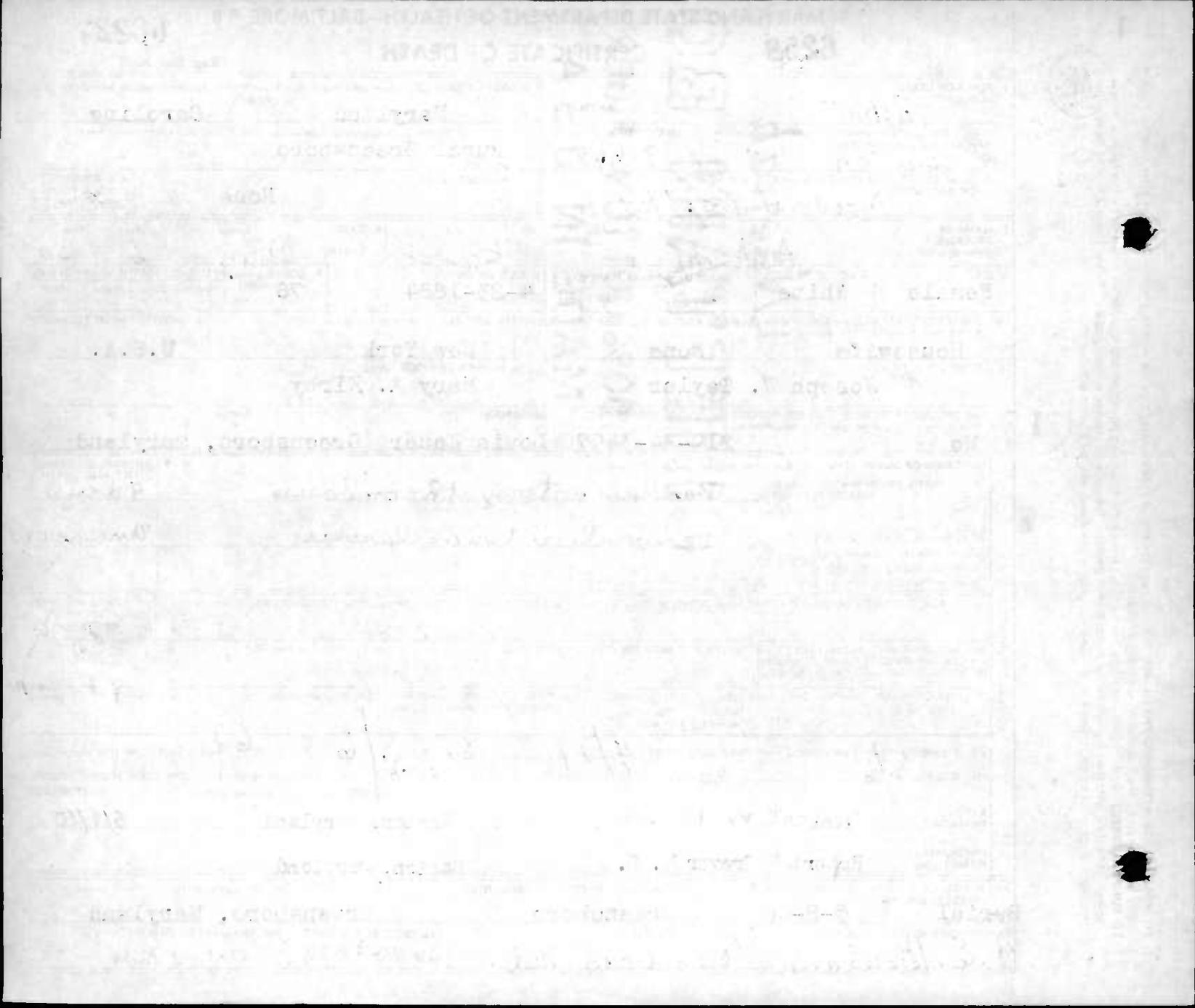
106227

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>9 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Achsa</i>		First <i>Achsa</i>	Middle <i>Kauer</i>
4. DATE OF DEATH <i>May 6 1960</i>		Lost <i>None</i>	Month Day Year
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4-23-1884</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph W. Taylor</i>		14. MOTHER'S MAIDEN NAME <i>Mary A. Kirby</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-34-3497</i>	
17. INFORMANT <i>Louis Kauer</i>		Address <i>Greensboro, Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Basilar artery thrombosis</i> DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Cerebral arteriosclerosis</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>9 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/27</i> , 19 <i>60</i> , to <i>5/6</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>5/6</i> , 19 <i>60</i> , and that death occurred at <i>11 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <i>Robert W. Trever</i> <i>5/7/60</i>	
ACTUAL SIGNATURE <i>Robert W. Trever</i>		M.D. <i>Easton, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>Robert W. Trever M. D.</i>		Easton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-8-60</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Greensboro</i>		22d. LOCATION (City, town, or county) (State) <i>Greensboro, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Boulaire Greensboro, Md.</i>		ADDRESS	
		24a. REC'D BY REGISTRAR DATE <i>MAY 12 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kauer</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 Film G262 5/12/60 ikw

16228

6260

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

o. COUNTY

Talbot

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Talbot

b. COUNTY

Md. Talbot Co.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL
Easton

c. LENGTH OF STAY IN 1b

2 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Memorial Hospital

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

40 Easton, Maryland.

d. STREET ADDRESS

200 Prospect Ave.

e. IS RESIDENCE ON A FARM?

YES NO 3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

5. SEX

6. COLOR OF RACE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

9. AGE (In years last birthday)

yrs.

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Months

Days

Hours

Min.

Ralph

Benjamin

Kirwan

May

6

1960

10a. USUAL OCCUPATION (Give kind of work done during most at working life, even if retired)

Salesman

10b. KIND OF BUSINESS OR INDUSTRY

Salesman

11. BIRTHPLACE (State or foreign country)

Dorchester Co. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Benjamin Kirwan

14. MOTHER'S MAIDEN NAME

Molly Webster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

Unknown

INFORMANT

Address

Le Compte Funeral Service, Cambridge, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Lymphosarcoma

INTERVAL BETWEEN
ONSET AND DEATH

12 years

DUE TO

200. Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 1920d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from May 4, 1960, to May 6, 1960, that I last saw the deceased alive on May 6, 1960, and that death occurred at 10:15 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Robert W. Trever

M.D.

PHYSICIAN'S
NAME (Type)22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

5/9/1960.

22c. NAME OF CEMETERY OR CREMATORI

Dorchester Memorial Park

22d. LOCATION (City, town, or county)

(State)

Cambridge, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE

Le Compte Funeral Service Cambridge

ADDRESS

24a. REC'D BY REGISTRAR
DATE MAY 9 '6024b. REGISTRAR'S SIGNATURE
Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

RECEIVED - MARINE CORPS RECRUITING STATION NEW YORK

HTAG TO RECRUIT

100-1000

002500

RECRUITED

RECRUIT

RECRUIT

RECRUITED

RECRUITED

RECRUITED

RECRUIT

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RECRUIT

RECRUITED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

106229

6261

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Talbot

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Easton

c. LENGTH OF STAY IN 1b

3 da

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE

Maryland

b. COUNTY

Talbot

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X rural

Easton

3. NAME OF
DECEASED
(Type or print)

Milton

First

Middle

Last

4. DATE
OF
DEATH

5

5

Month

Year

1960

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

May 16, 1890

9. AGE (In years
last birthday)

69 yrs.

10. IF UNDER 1 YEAR

Months

Days

11. IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

carpenter

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Robert P. Knox

14. MOTHER'S MAIDEN NAME

Sarah Jane Blockstone

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

218-03-5714

INFORMANT

Mrs. Milton B. Knox

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

332X

DUE TO

Cerebral Thrombosis

INTERVAL BETWEEN
ONSET AND DEATHacute
(3 days)Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

Cerebral arteriosclerosis

days

(c)

Generalized arteriosclerosis

year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m.
p. m. 1920d. INJURY OCCURRED
While Not while
of work of work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased
alive on _____, 19____, and that death occurred at _____, M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

L. J. Eglseder

M.D.

Easton, Md

5/7/60

PHYSICIAN'S
NAME (Type) L. J. Eglseder, M. D.

Easton, Maryland

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

May 9, 1960

22c. NAME OF CEMETERY OR CREMATORIUM

Spring Hill Cemetery

22d. LOCATION (City, town, or county)

Easton, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Maureen E. Newnam, Son

ADDRESS

Easton, Md

24a. REC'D BY REGISTRAR

DATE

MAY 10 '60

24b. REGISTRAR'S SIGNATURE

S. Thomas

HEARST STADIUM

221

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6262

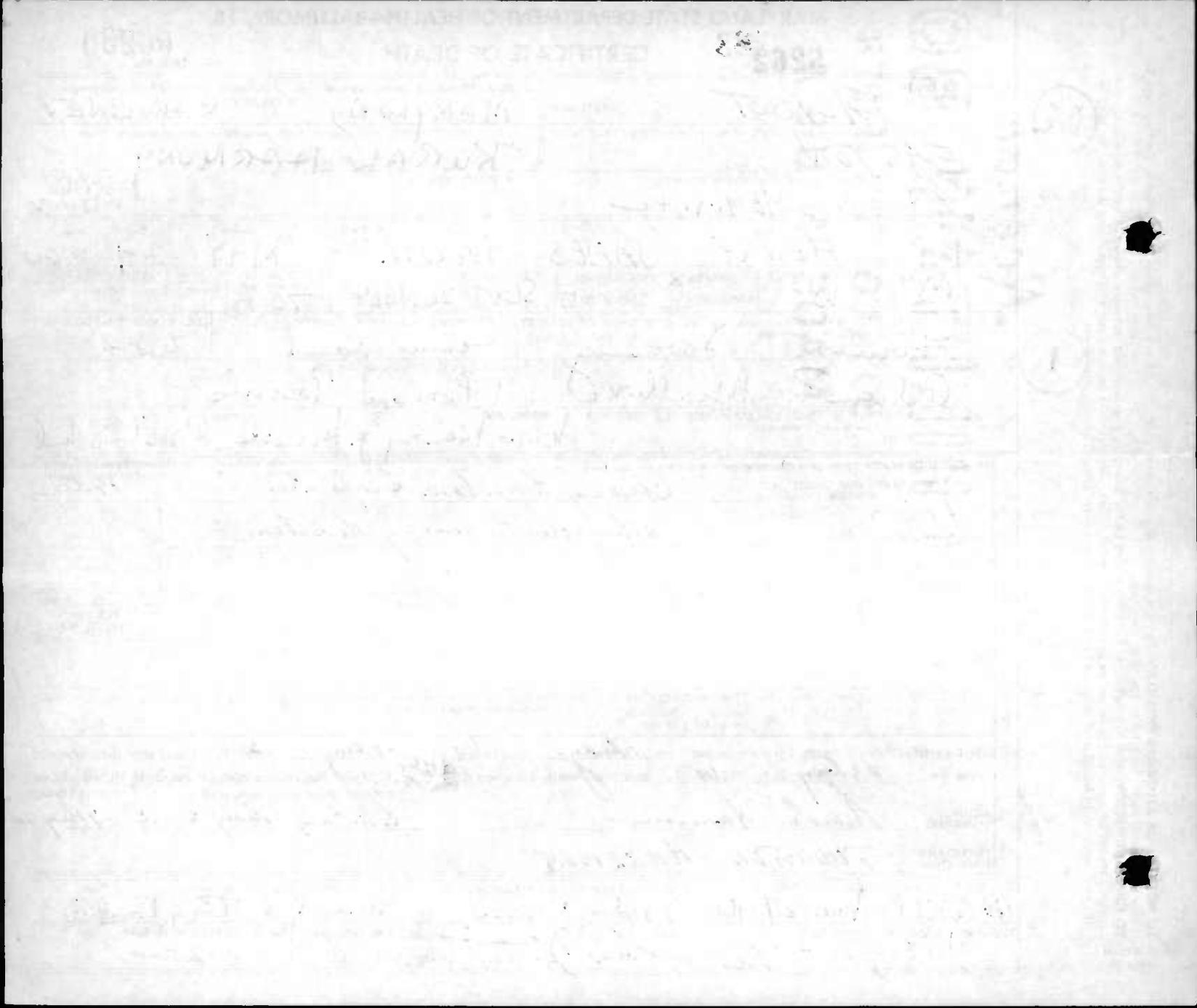
CERTIFICATE OF DEATH

06230

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON	c. LENGTH OF STAY IN 1b	b. COUNTY CAROLINE	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HARMONY 05X-2
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON MEMORIAL		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HENRY	Middle JAMES	Last MUELLER
4. DATE OF DEATH	Month MAY	Day 24	Year 1960
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 26, 1889
9. AGE (In years last birthday) 70 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Adam R. Mueller		
14. MOTHER'S MAIDEN NAME Theresa Bernie	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. INFORMANT	17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO Coarctation of aorta & infarction DUE TO atherosclerotic coronary thrombosis		
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH days
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year May 19
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Baltimore (County) Maryland (State) Md.			21. I certify that I attended the deceased from May 23 , 1960, to May 24 , 1960, that I last saw the deceased alive on May 23, 1960 , and that death occurred at 4 A.M. from the causes and on the date stated above.
ACTUAL SIGNATURE Arthur Harrison			ADDRESS (Street, city or town, state) Chesapeake Mayland 24 May 60
PHYSICIAN'S NAME (Type) ARTHUR HARRISON			DATE SIGNED
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 27, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Saints Cross	22d. LOCATION (City, town, or county) Near Edenton, Md. (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus	ADDRESS Reserve Tower, Baltimore	24a. REC'D BY REGISTRAR DATE Jun 1 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6263

CERTIFICATE OF DEATH

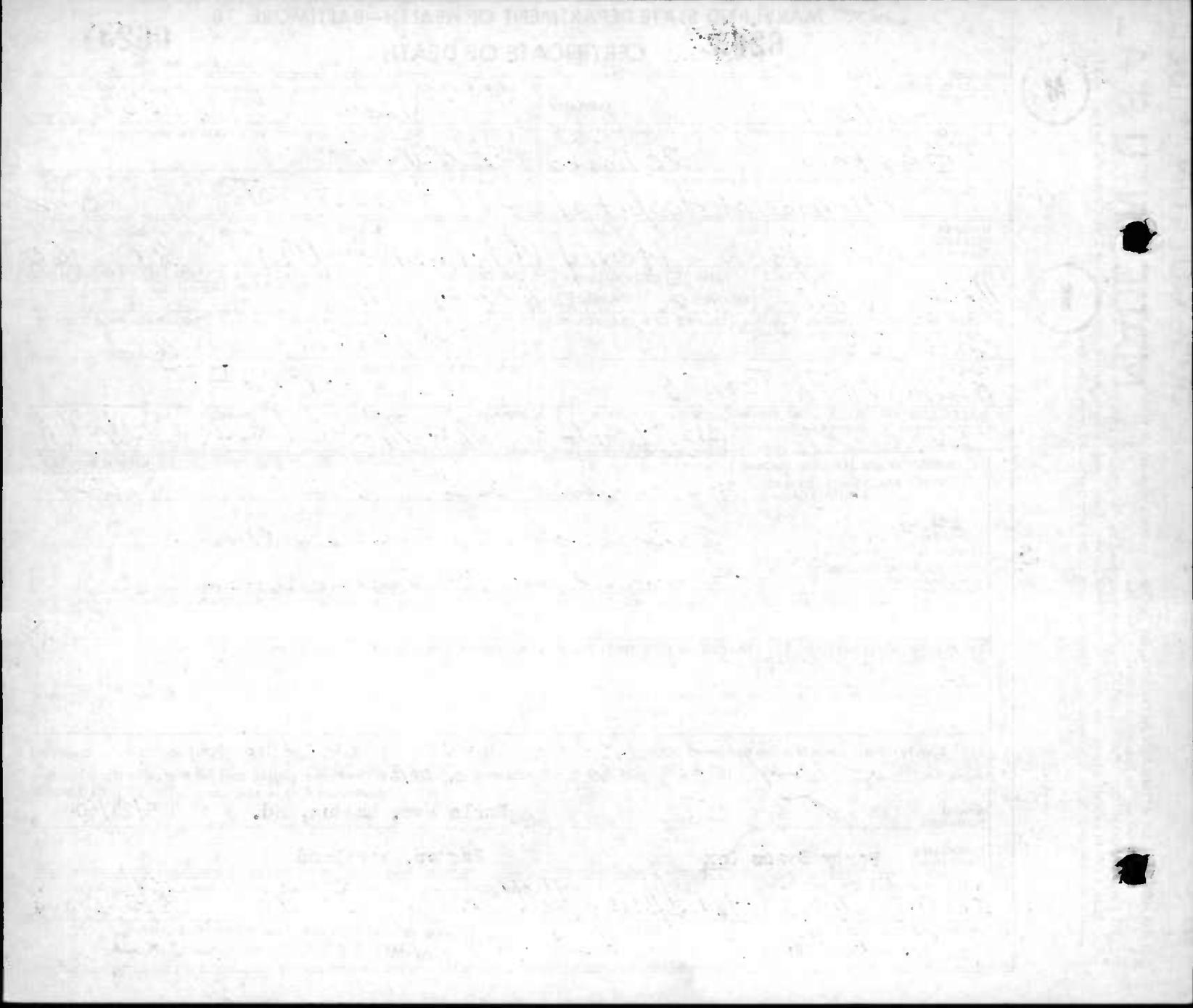
06231

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>TALBOT</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>		c. LENGTH OF STAY IN 1b <i>20 hours</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Mr. John</i>	Middle <i>Henry</i>	Last <i>Pritchard</i>
4. DATE OF DEATH	Month <i>May</i>	Day <i>21</i>	Year <i>1960</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>AUG. 21, 1871</i>
9. AGE (In years lost birthday) <i>88 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>CARPENTER.</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>RICHARD H. PRITCHARD</i>	14. MOTHER'S MAIDEN NAME <i>LOUISA CRAFT</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>219-34-2996 A</i>	INFORMANT <i>Mrs. Maril Smith</i>	Address <i>Easton, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>420.1</i>			
(b) <i>Arteriosclerotic Coronary Disease</i>			
DUE TO (c) <i>Generalized arteriosclerosis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5-14-1960</i> to <i>5-21-1960</i> that I last saw the deceased alive on <i>5-12-60</i> , and that death occurred <i>2:05 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. E. Cox</i>		ADDRESS (Street, city or town, state) <i>Earle Ave. Easton, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Percy Evans Cox</i>		DATE SIGNED <i>5/24/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 23, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Spring Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>Easton</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice H. Neuman & Son</i>		24a. REC'D BY REGISTRAR DATE <i>Curthia S. Kline</i>	
ADDRESS <i>Easton, Maryland</i>		24b. REGISTRAR'S SIGNATURE <i>Curthia S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

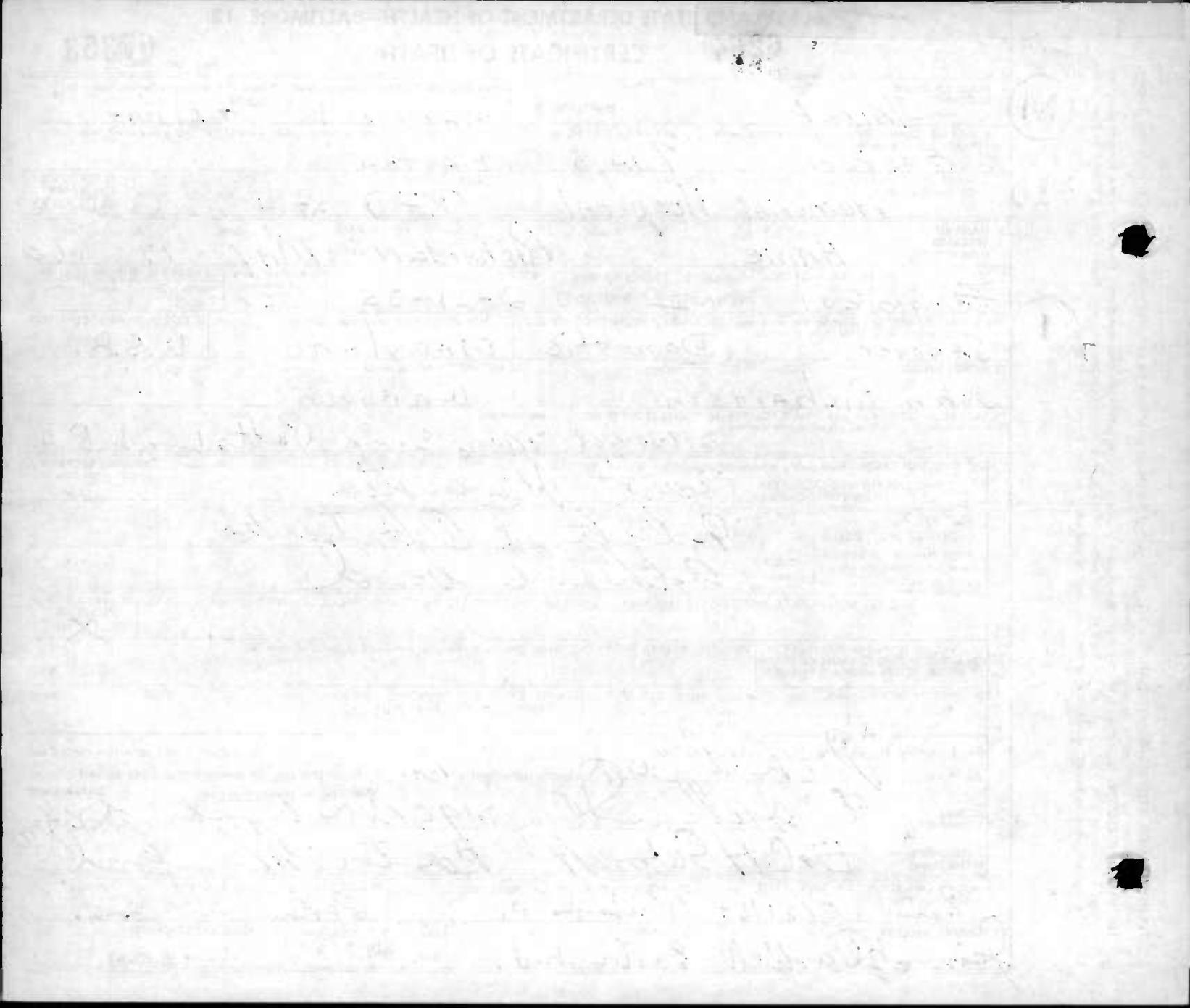
6264

CERTIFICATE OF DEATH

Reg. Dist. No.

07353

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be signed by the hospital or attending physician.		TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.																													
1. PLACE OF DEATH a. COUNTY		Jalbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		Maryland		Maryland		3. NAME OF DECEASED (Type or print)		First Annie Middle		4. DATE OF DEATH		Month May Day 19 Year 1960													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		RURAL EASTON		c. LENGTH OF STAY IN lb		7 days		X EASTON		X EASTON		5. SEX		Female		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Memorial Hospital.		13. FATHER'S NAME		John Richardson		WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>		2-21-05		55 yrs.		14. MOTHER'S MAIDEN NAME		Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address					
IMMEDIATE CAUSE (a)		570.5		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Acute Peritonitis		DUE TO		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO		Ante-terminal Obstruction		DUE TO		Adhesive band		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		ADDRESS (Street, city or town, state)		DATE SIGNED															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																					
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 1:10 A.M. from the causes and on the date stated above.		ACTUAL SIGNATURE		E.C.H. Schmidt		M.D.		ADDRESS (Street, city or town, state)		22. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, & county) (State)															
PHYSICIAN'S NAME (Type)		F. C. H. Schmidt		E. C. H. Schmidt		E. C. H. Schmidt		E. C. H. Schmidt		Burial		5/21/60		Richards Cem.		E. C. H. Schmidt		E. C. H. Schmidt													
23. FUNERAL DIRECTOR'S SIGNATURE		James Marshall		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE																							
VS A15 (4) 15M 9/5B		E. C. H. Schmidt		E. C. H. Schmidt		JUN 8 '60		Arthur L. Thomas																							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06232

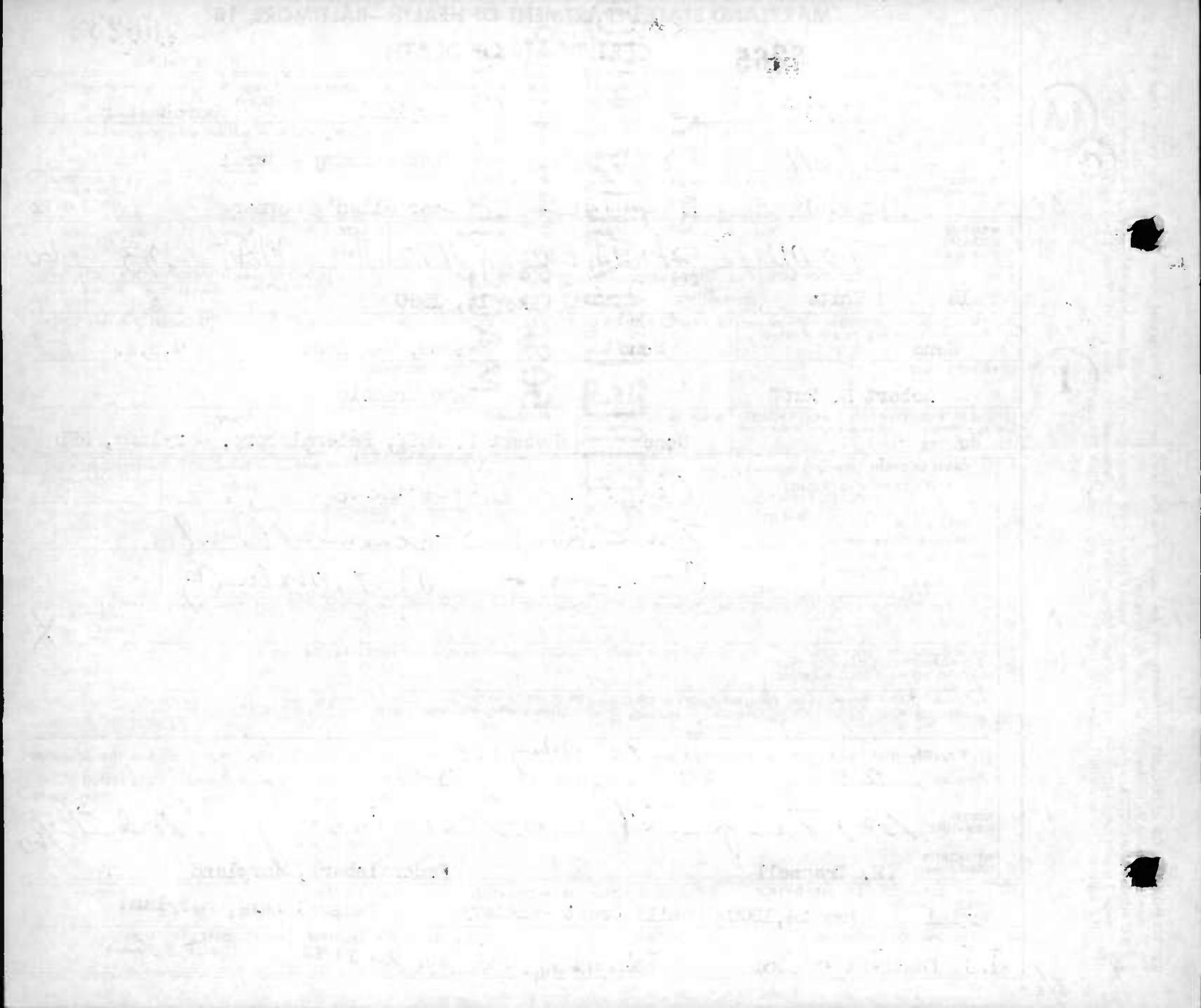
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 8 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) TO DOD		First ANDREW	Middle RUFF
		Last RUFF	4. DATE OF DEATH MAY 15, 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 15, 1960
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 8 yrs.	10. IF UNDER 1 YEAR Months 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Easton, Maryland
13. FATHER'S NAME Robert L. Ruff		14. MOTHER'S MAIDEN NAME Faye Bramble	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	INFORMANT Robert L. Ruff, Federalsburg, Maryland, RFD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) 761.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
Cerebral Anoxia			
True font in placenta Cord Position - Post Maternity			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 15 May 1960 , to 19 , that I last saw the deceased alive on 27 , 19 60 , and that death occurred at 3:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE H. Trapnell		ADDRESS (Street, city or town, state) Federalsburg, Maryland	
PHYSICIAN'S NAME (Type) H. Trapnell		DATE SIGNED 2nd 7/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 24, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Hill Crest Cemetery	22d. LOCATION (City, town, or county) Federalsburg, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE: J. J. Frampton and Son		ADDRESS Federalsburg, Md.	24a. REC'D BY REGISTRAR DATE MAY 31 '60
			24b. REGISTRAR'S SIGNATURE John J. Trapnell



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmGs63 5-20-60 et

6266

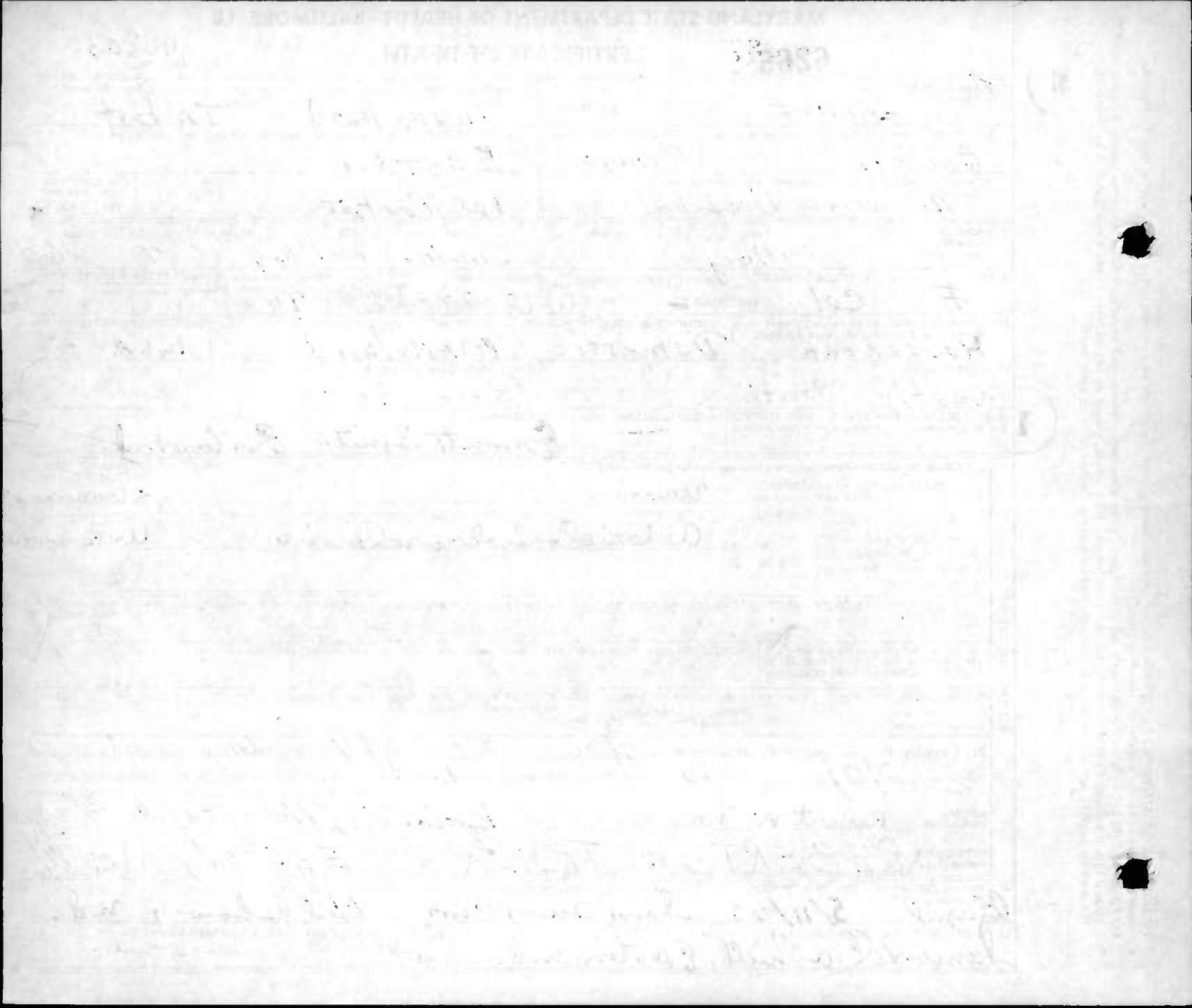
CERTIFICATE OF DEATH

116233

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>7 days-</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Mary</i>	Middle	Last 4. DATE OF DEATH <i>Smith - May 4 1960</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1886 12-24-1941</i>
9. AGE (In years last birthday) <i>74 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Housework</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Westly Smith</i>	14. MOTHER'S MAIDEN NAME <i>Rose Smith</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	INFORMANT <i>Emmett Smith</i>	Address <i>Easton, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Nremias</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Arterioloneysphrosclerosis</i>			
DUE TO (c) <i>Unknown</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4/30</i> , 19 <i>60</i> , to <i>5/7</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>5/7</i> , 19 <i>60</i> , and that death occurred at <i>Easton, Md.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert W. Trever</i>	PHYSICIAN'S NAME (Type) <i>ROBERT W. TREVER</i>	ADDRESS (Street, city or town, state) <i>Easton, Maryland</i>	DATE SIGNED <i>5/10/60</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5/11/60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Saint John Cem.</i>	22d. LOCATION (City, town, or county) <i>Hillsboro, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Dashiel, Easton, Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>MAY 17 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6267

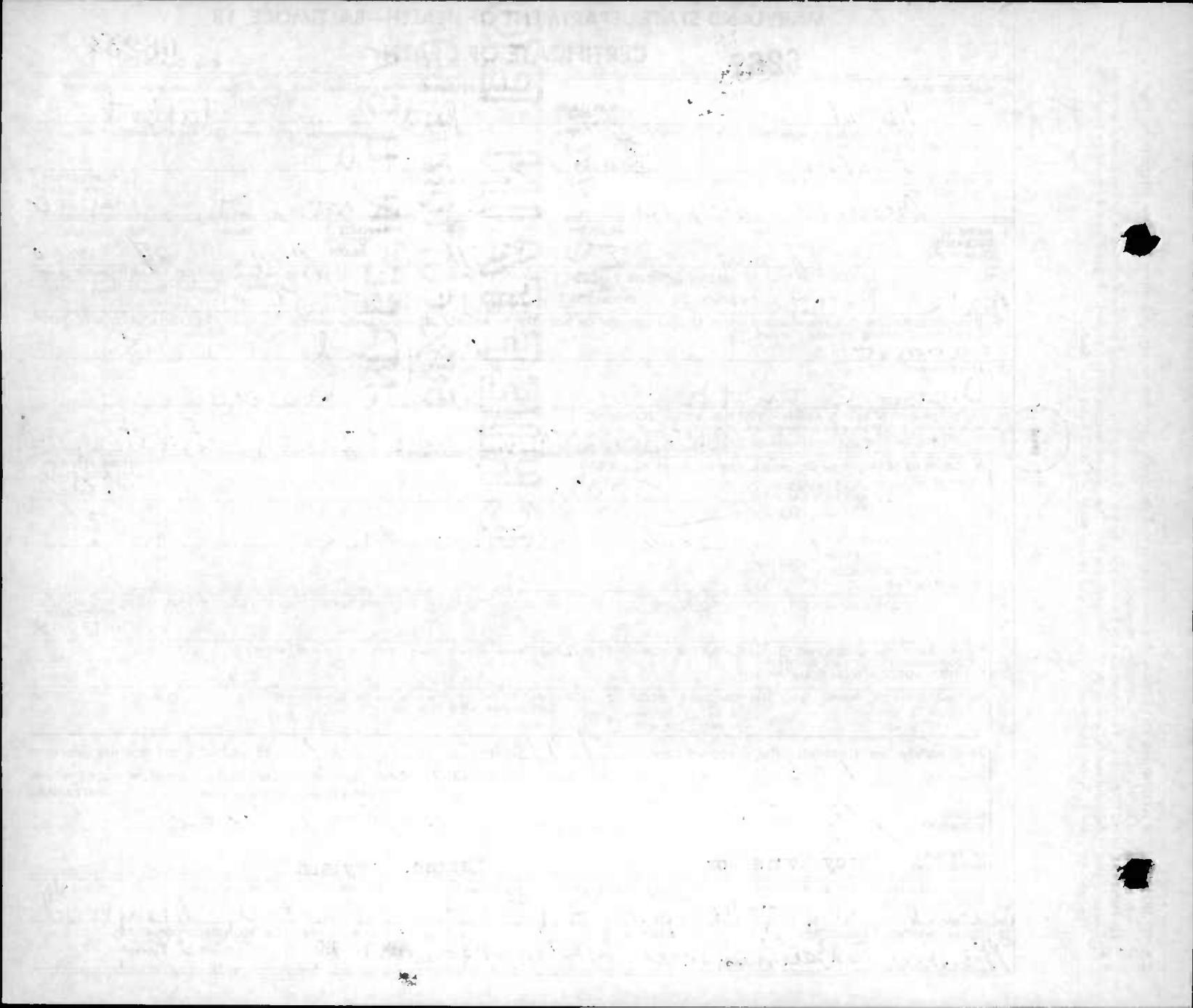
CERTIFICATE OF DEATH

06234
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>8 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>40 Easton</i>	
3. NAME OF DECEASED (Type or print) <i>Thomas</i>		First <i>T</i>	Middle <i>Smith</i>
4. DATE OF DEATH <i>May 27 1960</i>		Last <i>Smith</i>	Month <i>May</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>July 14, 1905</i>		9. AGE (In years last birthday) <i>54</i>	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <i>5</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Victor C. Smith</i>		14. MOTHER'S MAIDEN NAME <i>Bessie Rowens</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-36-2255</i>	
17. INFORMANT		Address <i>Mrs. Thomas T. Smith Easton, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>C. V.A.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral arteriosclerosis</i>		?	
DUE TO <i>331</i>		DUE TO <i>?</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Easton</i> (County) <i>Md.</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>5/19/60</i> to <i>5/26/60</i> , 1960, and that death occurred at <i>9:05 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Percy Evans Cox</i>		ADDRESS (Street, city or town, state) <i>Easton, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>Percy Evans Cox</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 30, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Spring Hill Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Easton, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice E. Neeram & Son</i>		24a. RECEIVED BY REGISTRAR DATE <i>May 31 1960</i>	
ADDRESS <i>Easton, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6268

CERTIFICATE OF DEATH

06235
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>6 1/2 hrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Solome Garey Somers</i>		First	Middle
		Last	
4. DATE OF DEATH <i>May 13 1960</i>		Month	Day
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>JUNE 2 1881</i>		9. AGE (In years lost birthday) <i>78 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Min. <i>05X-2</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>T. Frederick Garey</i>	
14. MOTHER'S MAIDEN NAME <i>Anna Dixon</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>Benjamin Somers Denton, Md.</i>		INFORMANT <i>(Address)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>(?)</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i>		(c) <i>Cardiovascular disease</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>13 May 1960</i> , to <i>13 May 1960</i> , that I last saw the deceased alive on <i>13 May 1960</i> , and that death occurred at <i>8:40 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Thornton Harrison</i>		M.D. ADDRESS (Street, city or town, state) <i>Denton</i> DATE SIGNED <i>13 May 60</i>	
PHYSICIAN'S NAME (Type) <i>THORSTON HARRISON</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
22b. DATE THEREOF <i>May 17 1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Denton</i>	
22d. LOCATION (City, town, or county) <i>Denton, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Virgil Dixon Son Denton, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 20 '60</i>	
ADDRESS <i>Denton</i>		24b. REGISTRAR'S SIGNATURE <i>John J. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

HEAVY DUTY TRUCKS

3400 E

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6269

CERTIFICATE OF DEATH

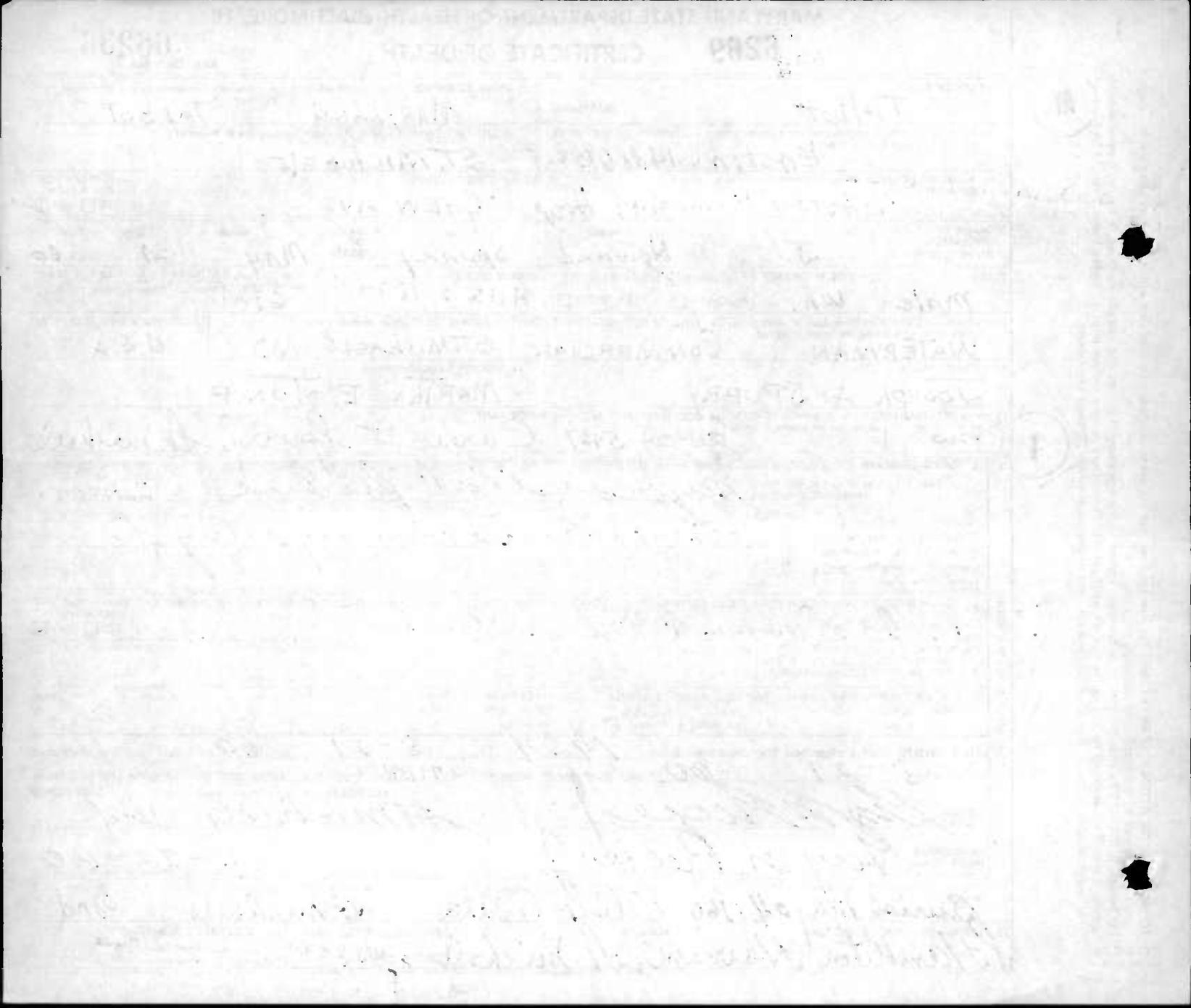
06236

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>14 days 6 1/2 hrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Easton Memorial Hosp.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X ST. MICHAEL'S</i>	
3. NAME OF DECEASED (Type or print) <i>J. Howard Spurry</i>		d. STREET ADDRESS <i>CHEW AVE</i>	
4. DATE OF DEATH Month <i>May</i>	Day <i>21</i>	Year <i>1960</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Wh.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>AUG 2. 1890</i>
9. AGE (In years lost birthday) yrs. <i>89</i>	10. KIND OF BUSINESS OR INDUSTRY <i>COMMERCIAL</i>	11. BIRTHPLACE (State or foreign country) <i>ST. MICHAEL'S MD</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>JOSEPH A. SPURRY</i>	14. MOTHER'S MAIDEN NAME <i>MARTHA E. JUMP</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>218-24-5487</i>	INFORMANT <i>Carrie W. Spurry, St. Michaels</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial failure</i>			
DUE TO <i>420.1</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>atherosclerotic coronary artery d-</i>			
DUE TO			
(c)			
INTERVAL BETWEEN ONSET AND DEATH <i>2 mos.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>cerebrovascular thrombosis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>St. Michael's</i>
(County) <i>MD</i>	(State) <i>MD</i>		
21. I certify that I attended the deceased from <i>1954</i> , 19, to <i>5-21</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>5-21</i> , 19 <i>60</i> , and that death occurred at <i>7:15 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John W. Reeder</i>		ADDRESS (Street, city or town, state) <i>St. Michael's MD</i>	
PHYSICIAN'S NAME (Type) <i>John W. Reeder</i>		DATE SIGNED <i>5-23-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 24, 1960</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Albion Cemetery</i>	22d. LOCATION (City, town, or county) <i>St. Michael's</i>
(State) <i>MD</i>	(State) <i>MD</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Hamilton Hamann, St. Michael's</i>	ADDRESS <i>St. Michael's</i>	24a. REC'D BY REGISTRAR <i>VS A15 (4)</i>	24b. REGISTRAR'S SIGNATURE <i>Caroline S. Moore</i>
		DATE <i>MAY 26 '60</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 - See Birth Certificate
6270 CERTIFICATE OF DEATH

06257

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>3 hrs -</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Baby Girl Stanley</i>		First	Middle
4. DATE OF DEATH <i>May 16 1960</i>		Last	Month Day Year
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>BLACK</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>5/15/60</i>		9. AGE (In years, lost birthday) <i>3 hours</i>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Maurice Stanley</i>		14. MOTHER'S MAIDEN NAME <i>Martha Virginia Ricketts</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>773.5</i>		INFORMANT <i>Martha Virginia Ricketts (mother)</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		Address <i>Federalsburg Md.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <i>Edema of Meninges Prematurity 2 lb 12 oz 3 hr</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5/15</i> , 19 <i>60</i> , to <i>5/16</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>5/15</i> , 19 <i>60</i> , and that death occurred at <i>3:10A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Federalsburg Md.</i>	
ACTUAL SIGNATURE <i>H. Trapnell</i>		DATE SIGNED <i>5-25-60</i>	
PHYSICIAN'S NAME (Type) <i>H. Trapnell</i>		Federalburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Incineration</i>		22b. DATE THEREOF <i>5/19/60</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Memorial Hospital</i>		22d. LOCATION (City, town, or county) (State) <i>Easton, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Incinerated - No funeral director</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 27 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Charles S. Knott</i>	

0552

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6271 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06238

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEFENDANT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any executive certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>		c. LENGTH OF STAY IN 1b <i>32 da.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>EDWARD</i>		First <i>Edward</i>	Middle <i>Townsend</i>
4. DATE OF DEATH <i>May 15 1960</i>		Month <i>May</i>	Day <i>15</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>4-13-87</i>		9. AGE (in years last birthday) <i>73 yrs</i>	10. IF UNDER 1YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Workers</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>N.C.</i>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>JACK Townsend</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Oliver</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line] or (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>916.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> DUE TO <i>(c)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>old cerebral hemorrhage</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>pants caught fire</i>	
20c. TIME OF INJURY Month, Day, Year <i>4:45 p.m. 1960</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>home</i>
		20f. (City or town) <i>Cordova</i>	(County) <i>Talbot</i>
		(State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED <i>5-18-60</i>	
ACTUAL SIGNATURE <i>Lewis Shultz</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>WELTY</i>			
22a. FUNERAL CREMATION REMOVAL (Specify) <i>Job Welsch</i>		22b. DATE OF FUNERAL <i>5-18-60</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Richards Cemetery</i>		22d. LOCATION (City, town, or county) <i>Easton, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Thomas</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE <i>MAY 24 '60</i>
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

STATE FOR
DODGE CITY

EXHIBIT 2 - STATE OF KANSAS - DODGE CITY	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6272

CERTIFICATE OF DEATH

06239

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY

TALBOT

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

EASTON

RURAL and give nearest town

c. LENGTH OF STAY IN 1b

26 hrs 40 min

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

EASTON Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge

09X-2

d. STREET ADDRESS

L.G. St.

e. IS RESIDENCE ON A FARM? YES NO

3. NAME OF DECEASED

(Type or print)

First

Middle

Last

TYNG

May

27

1960

S. SEX

Male

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

13/1855

9. AGE (In years and birthday)

yrs.

10. IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ministry - Retired

10b. KIND OF BUSINESS OR INDUSTRY

Conn.

11. BIRTHPLACE (State or foreign country)

U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Stephen Dyno

14. MOTHER'S MAIDEN NAME

Elizabeth Walworth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)191.4
Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

(b)

DUE TO

(c)

Cerebral embolism

Metastatic to mediastinum

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO

20c. TIME OF INJURY Month, Day, Year

Hour

o. m.

p. m.

19

20d. INJURY OCCURRED

While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from

19_____, to 19_____, that I last saw the deceased

alive on

19_____, and that death occurred at 20⁵ AM, from the causes and on the date stated above.ACTUAL
SIGNATURE

ADDRESS (Street, city or town, state)

DATE SIGNED

PHYSICIAN'S
NAME (Type)22g. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

5/30/60

22c. NAME OF CEMETERY OR CREMATORIUM

Blue Mills

22d. LOCATION (City, town, or county)

Blue Mills Md

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Burke & Hollingsby East New Market

24a. REC'D BY REGISTRAR

DATE JUN 2 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

